Jason Duchinsky MA, LPC
INFORMED CONSENT
Call to Action

Thank you choosing to see me, Jason Duchinsky, MA, LPC.
Appointments will take approximately 50 – 55 minutes. I realize that beginning professional counseling is a major decision and you may have questions. This document is intended to inform you of my policies and relevant legal and ethical requirements. If you have any other questions or concerns, please ask and I will try my best to provide you the information you need.

CONFIDENTIALITY AND EMERGENCY SITUATIONS: *Your verbal communications and clinical records are strictly confidential, privileged except for:*

a) *information (diagnosis and dates of service) shared with your insurance company to process your out of network claims,*
b) *information you and or a family member report regarding physical or sexual abuse and or neglect of a child; then, by Missouri State Law, I am obligated to report this to the Department of Family Services,*
c) *information necessary (excluding personal identifying information) to consult and or receive supervision from a licesensed mental health professional to meet ethical, legal, continuing education and or training requirements,*
d) *where you sign a release of information to have specific information shared and*
e) *if you provide information that informs me that you are an imminent harm to yourself or others.*

Signature(s)_____Date:_____

FINANCIAL ISSUES: *I ask that after each session (in person and or telehealth) you pay the full fee unless prior arrangements have been made.*

If you need to cancel or reschedule an appointment, please provide 24 hours' notice or you may be charged for the missed session.

Signature(s)_____Date_____

COORDINATION OF TREAMENT: *It is important that all health care providers work together. As such, I would like your permission to communicate with your primary care physician and/or psychiatrist. Your consent is valid for the length of our professional relationship. If you prefer to decline consent no inform will be shared.*

____You may inform my physician(s) ____I decline to inform my physician

PHYSICIAN NAME: _____PHONE:_____
CLINIC:_____ADDRESS:_____

Signature(s)_____Date_____

May I contact you at home (circle one) ***yes no?*** *May I contact you at work* ***yes no?*** *May I contact you by cell phone* ***yes no?***
Where/when is the best time/place to contact you?_____

Call to Action, Consent to text

I agree to receive text communications at the cell phone number provided from Jason Duchinsky, MA, LPC.

Signature(s)_____Date_____

Cell phone number _____